

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - A-04  
(June 2004)

Subject: Impact of the Health Maintenance Organization Act of 1973

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1 At the 2003 Annual Meeting, the House of Delegates adopted Resolution 214, which calls for the  
2 AMA to provide an update on the impact of the Health Maintenance Organization Act of 1973.  
3 The Board of Trustees referred Resolution 214 (A-03) to the Council on Medical Service for study,  
4 with a report back to the House at the 2004 Annual Meeting.  
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6 This report, which is presented for the information of the House, focuses on the maturation of the  
7 managed care market over the past three decades. Specifically, it highlights the role that the AMA  
8 has played in advocating for patients and physicians on a variety of managed care issues. Over the  
9 past 10 years alone, the Council on Medical Service has presented 55 reports to the House of  
10 Delegates on issues related to managed care. These reports have contributed to the extensive AMA  
11 policy base that has facilitated improvements in the managed care practice environment for  
12 physicians and their patients. Ongoing AMA advocacy efforts are also highlighted in this report.  
13

### 14 BACKGROUND

15  
16 Due in large part to the creation and implementation of the Medicare and Medicaid programs,  
17 federal health care spending jumped from \$39 billion in 1965, to \$75 billion in 1971. The increase  
18 in federal spending was attributed by some policymakers to the “unregulated” use of these two new  
19 programs. Accordingly, as early as March 1970, the Department of Health, Education and Welfare  
20 proposed the possible use of federally-supported health maintenance organizations (HMOs) as an  
21 alternative for Medicare (Campion, *The AMA and U.S. Health Policy Since 1940*, 1984).  
22

23 In February 1971, President Richard Nixon challenged Congress to develop a strategy to use the  
24 government to move health care coverage from traditional indemnity insurance to prepaid health  
25 care (Mitka, *JAMA*, December 1998). By early 1972, 110 HMO planning and development grants  
26 had been funded, and President Nixon continued to advocate for HMOs as a means of expanding  
27 patient choice. Following a number of hearings, at which some members of Congress stressed the  
28 need to test the concept of HMOs before making a “wholesale federal commitment to the idea,” the  
29 HMO Act of 1973 (42 U.S.C. Sec. 300 et. seq.) was passed (Campion, *The AMA and U.S. Health  
30 Policy Since 1940*, 1984).  
31

32 The HMO Act of 1973 stimulated private sector growth of HMOs by providing \$375 million for  
33 development and subsidization of HMO premiums, and requiring private employers with 25  
34 employees or more to offer HMOs. For the short term, the legislation provided the start-up funding  
35 for HMOs to get into the business, and served to legitimize the concept of HMOs to employers.  
36 For the long-term, the HMO Act set the stage for the development of preferred provider  
37 organizations (PPOs), point-of-service plans, and other forms of managed care. While there is no  
38 question that the HMO Act of 1973 ushered in all forms of managed care, the effect of the actual  
39 legislation was limited by the passage of other managed care-related legislation, as well as the  
40 evolution of the private health care marketplace.

1 LEGISLATIVE HISTORY

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3 Over the years, a number of legislative actions have altered the jurisdiction of the HMO Act. Most  
4 prominently, court interpretations of the Employment Retirement Income Security Act (ERISA) of  
5 1974 (29 U.S.C. Sec. 18 et. seq.) have preempted the control that the HMO Act had over most  
6 managed care products. ERISA set minimum federal standards for most voluntarily established  
7 pension and health plans in the private sector to protect individuals in these plans. Currently, there  
8 exist very few federally qualified HMOs as defined by the HMO Act. The following additional  
9 legislative actions have had a direct impact on the provisions of the HMO Act:

- 10  
11 • 1976 - The HMO Act was amended to relax requirements for “qualified” HMOs.  
12  
13 • 1978 - Amendments extended the HMO assistance program for 3 years.  
14  
15 • 1981 - Legislation eliminated almost all requirements of the HMO Act.  
16  
17 • 1982 - A provision in the Tax Equity and Fiscal Responsibility Act of 1982 (26 U.S.C. Sec.  
18 6031) mandated further reductions in many federal health programs; required employers with  
19 20 or more employees to offer active employees and their spouses aged 65-69 the same level of  
20 health care benefits offered to younger employees.  
21  
22 • 1988 - The HMO Act was rewritten to allow experience rating by HMOs and to allow  
23 employers to contribute less to HMO plans than to indemnity options.  
24  
25 • 1997 - The Balanced Budget Act of 1997 (P.L. 105-33) added new Part C to Medicare  
26 (i.e. Medicare + Choice), expanding options for enrollment in managed care plans.  
27  
28 • 2003 - The Medicare Prescription Drug, Improvement, and Modernization Act of 2003  
29 (P.L. 108-173) replaced the Medicare+Choice program with a new program called Medicare  
30 Advantage, which operates under Part C of Medicare.  
31

32 MARKET PENETRATION IN THE PRIVATE SECTOR

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34 Over the past 30 years, managed care market penetration in the private sector has grown steadily.  
35 In 2003, 63.3% of health plan enrollees were enrolled in managed care plans. Yet, HMO  
36 enrollment peaked in 1999. Of the 184.7 million people enrolled in managed care plans in 2003,  
37 only 71.8 million were enrolled in HMOs, representing a 12% decline from the 81.3 million HMO  
38 enrollees in 1999. Recent trends show a continued growth in PPO enrollment, as enrollees shift out  
39 of HMOs and traditional indemnity insurance plans.  
40

41 On a geographic basis, the level of HMO penetration varies greatly from state to state. According  
42 to 2003 data from Interstudy, the following are among the states with lower than 5% HMO  
43 penetration: North Dakota (0.4%), Mississippi (0.8%), Wyoming (2.4%), Idaho (2.8%), and  
44 Alabama (3.8%). In contrast, the following states have HMO market penetrations that are over  
45 30%: California (48.5%), Massachusetts (38.7%), Connecticut (37.8%), New York (32.4%) and  
46 Pennsylvania (31.7%).

1 Concentrated health insurance markets (e.g., HMO market share, PPO market share, combined  
2 HMO/PPO market share) are raising serious concerns about the market power of health insurers.  
3 For example, the AMA publication “Competition in Health Insurance: A Comprehensive Study of  
4 US Markets, 2003 Update,” found that:

- 5
- 6 • In 88% (23) of the 26 state-level markets studied, there is at least one insurer in each market  
7 that has a combined HMO/PPO market share in excess of 30%.
- 8
- 9 • In 42% (11) of the 26 state-level markets studied, there is at least one insurer in each market  
10 that has a combined HMO/PPO market share in excess of 50%.
- 11

12 The level of HMO/PPO market penetration is even more evident within metropolitan statistical  
13 areas of individual states. In terms of metropolitan areas, most health insurance markets are  
14 dominated by a few companies:

- 15
- 16 • In 90% (76) of the 84 metropolitan area markets studied nationally, there is at least one insurer  
17 in each market that has a combined HMO/PPO market share in excess of 30%.
- 18
- 19 • In 37% (31) of the 84 metropolitan area markets studied nationally, there is at least one insurer  
20 in each market that has a combined HMO/PPO market share in excess of 50%.
- 21

## 22 HEALTH PLAN MERGERS

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24 Increasingly, health plan mergers are also responsible for playing a larger role in shaping the  
25 managed care industry. According to the AMA’s second edition of *Competition in Health*  
26 *Insurance: A Comprehensive Study of US Markets*, there were over 384 managed care mergers and  
27 acquisitions between 1995 and 2002.

28

29 Consolidations reduced the number of Blue Cross and Blue Shield plans from 67 to 41 between  
30 1995 and 2003. Most recently, Anthem, Incorporated announced its plans to purchase WellPoint  
31 Health Networks in a \$16.4 billion cash and stock merger to create WellPoint, the country’s largest  
32 health insurer (25 million lives covered). UnitedHealth Group also announced its plans to purchase  
33 Oxford Health Plans for \$4.7 billion. As of March 2004, the top 10 largest national health plans  
34 covered at least 50% of commercially insured persons. The acceleration of health plan mergers is  
35 perceived by some policymakers as the key force in increasing the market power among insurers in  
36 major metropolitan markets.

37

38 In combination with growing market penetration, this increase in mergers has enhanced the ability  
39 of the remaining insurers to potentially exert greater control over local markets, dictate physician  
40 contract terms, and maximize premium revenue. The AMA’s Private Sector Advocacy unit found  
41 that health insurance premiums have increased by more than 42% overall from 1998 to 2002,  
42 which is more than double the overall increase in medical inflation (17%) and triple the increase in  
43 overall inflation (10%) during the same time period. Consolidation of health plans is one area that  
44 the AMA is continuing to monitor.

1 CURRENT PHYSICIAN PERCEPTIONS OF MANAGED CARE

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3 The August 2003 AMA publication *Portrait of Physicians* summarized findings on physician job  
4 satisfaction and autonomy in relation to managed care, based on a review of 22 studies that were  
5 published between 1995 and 2003. Among the key findings of these reviews were the following:  
6

- 7 • Physicians, especially those who contract with multiple health plans, express negative views of  
8 managed care and have significant concerns about the effects of managed care on their ability  
9 to provide high-quality care to their patients.
- 10
- 11 • Due to increasing rules and regulations set by managed care organizations, physicians are  
12 finding that their professional autonomy has decreased in a variety of areas.
- 13
- 14 • Factors that affect the level of professional autonomy expressed by physicians seem to be  
15 related to the level of HMO penetration and the number of managed care plans with which the  
16 physician is involved or has contracts.
- 17
- 18 • The level of professional autonomy expressed by physicians is also related to the practice  
19 setting.
- 20
- 21 • Adequate participation in a managed care setting during training greatly increases satisfaction  
22 with managed care and the likelihood that a physician will be satisfied with the level of  
23 autonomy in a managed care setting.
- 24
- 25 • Experience with a managed care environment, specifically capitation, over the period of a year,  
26 decreased physicians' dissatisfaction with the system.
- 27
- 28 • In response to the "managed care backlash," some health insurers have loosened restrictions on  
29 prior authorization for some services, tests and procedures, as well as referrals to specialists.
- 30

31 AMA POLICY

32  
33 Over the past 30 years, the AMA has established a comprehensive policy base on managed care.  
34 Perhaps of most significance is the AMA's long-standing policy that continues to advocate that the  
35 needs of patients are best served by free market competition and free choice by physicians and  
36 patients among all modes of health care delivery and financing, with the growth of each system  
37 determined not by preferential regulation and subsidy, but by the number of persons who prefer  
38 that mode of delivery or financing (Policies H-165.985[1] and H-285.998[1], AMA Policy  
39 Database). The AMA has long-supported the enactment of comprehensive legislation that  
40 addresses a wide range of patient protection and physician fairness issues, such as disclosure of  
41 health plan information to enrollees and prospective enrollees, utilization review and grievance  
42 procedures, due process in physician selective contracting decisions, and physician involvement in  
43 health plan medical policies (Policies H-285.941 and H-285.981). In addition, the AMA has  
44 continued to strongly advocate for changes in relevant antitrust laws to allow physicians and  
45 physician organizations to engage in collective negotiations with purchasers, managed care plans,  
46 and other insurers (Policy H-165.944[4], H-165.942[2], H-165.924, H-385.946, and H-380.987).

1 Among the additional managed care issues for which the AMA has established significant policy  
2 are the following: disclosure provisions (H-285.998[5], H-140.978 [4, 5], H-285.984 [3]), and  
3 H-285.998[3]); selective contracting (H-285.991 [1,a], H-285.984[2], H-285.991[b], H-230.975[1],  
4 H-285.991 [1,c], H-285.997[2], and H-285.991[1,d]); credentialing and recredentialing  
5 (H-285.948, H-285.979, H-285.953, H-285.979, and H-285.934); case management (H-285.998[4],  
6 H-385.951, H-390.878, H-285.998[4], H-200.969[4], H-285.998[4], H-165.908[1,2], and  
7 H-165.903); financial incentives (H-140.941, H-285.951[d], E-6.03, E-8.052, and H-285.951  
8 [c, h, i, g]); managed care contracts (H-285.946, H-285.952, H-285.963[2], H-285.951 [b, l, j, k],  
9 H-285.940, H-285.996, H-285.932[2], H-140.942, H-285-989, H-385.989, H-385.938, H-285.955,  
10 H-285.995[1], H-285.943, H-285.947, and H-415.987); physician decision-making H-285.954[1],  
11 H-285.931, H-165.909, H-285.983, and H-165.909[2]); utilization review (H-320.953,  
12 H-285.998[5], H-320.968[2a, 2b, 2d, 2e, 3], H-165.951 [3, e4], H-320.969[4], H-285.994[3], and  
13 H-285.945); independent and external review (H-320.968 [2,c], and H-320.952); disease  
14 management (H-285.944); telephone triage and counseling (H-285.944 and H-160.935); hospitalist  
15 programs (H-285.964); medical director qualifications (H-285.987, and H-285.939); and Medicare  
16 and Medicaid managed care (H-290.984, H-330.916, H-290.985, H-290.982[10], H-400.955, and  
17 H-285.957).

18  
19 These policies, many of which the Council on Medical Service recommended for adoption by the  
20 House of Delegates, are included in the fourth edition of the AMA's *Principles of Managed Care*,  
21 which the Council is updating for 2004.

## 22 CURRENT AMA ADVOCACY EFFORTS

23  
24 Reflective of its voluminous policy on managed care, the AMA has implemented a number of  
25 initiatives to address the concerns raised by physicians and patients. In 1998, the AMA created its  
26 Private Sector Advocacy unit, which is charged with addressing abusive and unfair business  
27 practices by HMOs and health insurers, and bringing greater equity to managed care practices. The  
28 main activities of the Private Sector Advocacy unit include, but are not limited to, health claims  
29 processing issues, health plan capitation, health plan contracting issues, health plan delayed or  
30 reductions in payment, health plan complaints, managed care trends and strategies, marketplace  
31 and financial analyses, and anti-trust reform. Among the key products that have been developed by  
32 Private Sector Advocacy are the following:  
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- 34  
35 • A model managed care contract, designed as an alternative to one-sided contracts typically  
36 offered by health insurers.
- 37  
38 • "Claims Management Resource Kit," a practical tool to help physicians collect prompt, fair  
39 reimbursement.
- 40  
41 • A national prompt payment brochure created to help physicians understand what they can do to  
42 expedite delinquent payments as a part of a national prompt payment campaign, and which  
43 highlights the AMA's legislative and regulatory successes in the area of prompt payment (i.e.,  
44 legislative and regulatory successes).
- 45  
46 • State specific prompt payment brochures for physicians and patients for the Maine Medical  
47 Association, the Florida Medical Association, and the Michigan State Medical Society.

- 1 • *A Comprehensive Study of U.S. Markets*, a complete study on the competitiveness of health  
2 insurance markets in the U.S.  
3
- 4 • Health Plan Complaint Form, which gives physicians and their staff an opportunity to provide  
5 the AMA with critical data on the hassles physicians experience on a day-to-day basis in the  
6 managed care environment. This information is critical in helping the AMA identify and  
7 combat unfair health insurer and payer business practices.  
8
- 9 • The HIPAA Complaint Form, which can be used to inform the AMA about health plans and  
10 other payers that are out of compliance with the Health Insurance Portability and  
11 Accountability Act (HIPAA) electronic transaction and code set standards.  
12
- 13 • Three new anti-trust documents, including: “Anti-Trust 101,” a basic resource document  
14 created to educate physicians about the realities of the current antitrust environment; “What is a  
15 Messenger Model,” which provides key points on the messenger model and its processes; and  
16 “Recent FTC Enforcement Actions Taken Against Physicians for Joint Negotiations with  
17 Health Plans,” an extensive report detailing the 13 cases that have been settled with the FTC.  
18

19 The above resources and other related documents can be accessed via the AMA Private Sector  
20 Advocacy website at [www.ama-assn.org/go/PSA](http://www.ama-assn.org/go/PSA).  
21

22 In addition, the Litigation Center of the AMA/State Medical Societies was created as a means to  
23 effectively advocate for the legal interests of the medical profession in the courts by bringing forth  
24 cases of broad impact, and by serving as an information and legal advocacy clearinghouse for a  
25 coalition consisting of the AMA and all 50 state medical associations, as well as the Medical  
26 Society of the District of Columbia. The Litigation Center addresses legal issues such as disputes  
27 with managed care organizations, fraud and abuse claims against physicians, relationships between  
28 hospitals and their medical staffs, medical liability and the burden of governmental regulations.  
29 The Litigation Center concentrates its legal resources on filing lawsuits or *amicus curiae* briefs in  
30 cases of general interest to physicians, and on sharing information and resources in response to  
31 emerging legal issues.  
32

33 For example, an ongoing class action lawsuit filed by many state medical associations on behalf of  
34 more than 600,000 physicians, charges wholesale fraud in the payment practices of ten of the  
35 largest managed care organizations in the United States. The principal allegations are that the  
36 defendants, though edits in their payment software, have breached their physician provider  
37 contracts, violated state prompt payment laws, and conspired to violate the federal Racketeer  
38 Influenced and Corrupt Organizations Act. Recently, Aetna and CIGNA insurance companies  
39 agreed to stop certain of their bundling practices, disclose others publicly, and pay approximately  
40 \$200 million in damages to physicians. The AMA, while not a party to the consolidated complaint,  
41 provided technical support on CPT and other payment issues to the plaintiff medical associations  
42 and to counsel for the plaintiff class.  
43

44 Since January 1, 2000, the AMA Litigation Center has supported 62 cases representing physician  
45 and patient interests, ranging from state-level trial courts to the U.S. Supreme Court. One of the  
46 more notable Supreme Court cases was *Rush Prudential v. Moran*, which upheld the right of states  
47 to enforce independent review laws for HMO enrollees. The patient’s physicians in *Rush*

1 *Prudential v. Moran* case were longtime AMA members, and the AMA Litigation Center filed  
2 *amicus curiae* briefs supporting the patient in the appeals.

3

4 CONCLUSION

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6 It is clear that passage of the HMO Act of 1973 spurred the development of HMOs, as well as the  
7 subsequent growth in the managed care industry. Nonetheless, the passage of subsequent federal  
8 legislation has significantly altered the jurisdiction of the HMO Act. Today, the HMO Act has  
9 very little direct bearing on the managed care industry.

10

11 As current AMA policy and ongoing advocacy initiatives indicate, however, physicians and  
12 patients continue to seek assistance from the AMA in addressing a number of problems with  
13 managed care plans. In particular, the AMA continues to be asked to address unfair health plan  
14 contract provisions, assist in state-level prompt payment legislation, and intercede with respect to  
15 the misapplication of CPT codes and guidelines that often result in inappropriately denied  
16 payments to physicians and other non-physician health care professionals.

17

18 The AMA will continue to strongly advocate on behalf of patients and physicians, and the Council  
19 on Medical Service will remain a constant and vigilant force in undertaking further studies and  
20 generating proposed policies that are responsive to emergent issues related to managed care.

References for this report are available from the AMA Division of Socioeconomic Policy  
Development.

Fiscal Note: None